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facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)

b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of $50.00 per day for the first thirty days and a penalty of $100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Division Director of Nursing Home Reimbursement Services prior to September 30.

c. If a cost report is received by the Division prior to September30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.

d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial

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information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross- referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

f. All nursing facilities are required to submit to the Division any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be

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deducted from the monthly reimbursement check. The assessments will not be refunded.

h. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data, with the appropriate Dodge Index property rate. If the new owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates, the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was

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prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.

j. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.

k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate workpapers or letters of explanation should be attached.

l. All cost reports and correspondence concerning these cost reports are to be mailed to the following address:

Division of Medical Assistance
Nursing Home Services Unit
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a

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Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.

b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category.

c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.

d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.

e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.

f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Cognitive Performance Scale (CPS) score.

g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments will

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be processed as adjustments to rate calculations in a subsequent period. If a prospective correction would otherwise result in excess or advance payments of material amounts, with materiality determined by the amount or percentage of payment, the Division will process the correction by a retrospective adjustment to prior payments.

A detailed description of all data elements in the Case Mix Index Report is presented in Exhibit D-2.

5. Nursing Hours and Patient Day Report

Except for ICF-MR and state owned facilities, each facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

If a facility does not submit a report or does not submit a report when due, a late fee of $10 per day may be assessed.

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EXHIBIT D-1

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
1	Extensive	Extensive Special Care 3 / ADL > 6	SE3	2.839	2.896
2	Extensive	Extensive Special Care 2 / ADL > 6	SE2	2.316	2.362
3	Rehabilitation	Rehabilitation All Levels / ADL 17-18	RAD	2.284	2.330
4	Extensive	Extensive Special Care 1 / ADL > 6	SE1	1.943	1.982
5	Rehabilitation	Rehabilitation All Levels / ADL 14-16	RAC	1.936	1.975
6	Special Care	Special Care / ADL 17-18	SSC	1.877	1.915
7	Rehabilitation	Rehabilitation All Levels / ADL 9-13	RAB	1.772	1.807
8	Special Care	Special Care / ADL 15-16	SSB	1.736	1.771
9	Special Care	Special Care / ADL 4-14	SSA	1.709	1.743
10	Rehabilitation	Rehabilitation All Levels / ADL 4-8	RAA	1.472	1.501
11	Clinically Complex	Clinically Complex with Depression / ADL 17-18	CC2	1.425	1.454
12	Clinically Complex	Clinically Complex / ADL 17-18	CC1	1.311	1.337
13	Clinically Complex	Clinically Complex with Depression / ADL 12-16	CB2	1.247	1.272
14	Physical	Physical Function with Nursing Rehab / ADL 16-18	PE2	1.188	1.212
15	Clinically Complex	Clinically Complex / ADL 12-16	CB1	1.154	1.177
16	Physical	Physical Function with Nursing Rehab / ADL 11-15	PD2	1.095	1.117
17	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 6-10	IB2	1.061	1.082
18	Clinically Complex	Clinically Complex with Depression / ADL 4-11	CA2	1.043	1.064
19	Physical	Reduced Physical Function / ADL 16-18	PE1	1.077	1.077
20	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 6-10	BB2	1.021	1.041
21	Physical	Reduced Physical Function / ADL 11-15	PD1	0.990	0.990
22	Impaired Cognition	Cognitive Impairment / ADL 6-10	IB1	0.938	0.957
23	Physical	Physical Function with Nursing Rehab / ADL 9-10	PC2	0.937	0.956

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	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
24	Clinically Complex	Clinically Complex / ADL 4-11	CA1	0.934	0.953
25	Behavioral Problems	Behavior Problem / ADL 6-10	BB1	0.866	0.883
26	Physical	Physical Function with Nursing Rehab / ADL 6-8	PB2	0.824	0.841
27	Physical	Reduced Physical Function / ADL 9-10	PC1	0.865	0.865
28	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 4-5	IA2	0.777	0.777
29	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 4-5	BA2	0.750	0.750
30	Physical	Reduced Physical Function / ADL 6-8	PB1	0.749	0.749
31	Impaired Cognition	Cognitive Impairment / ADL 4-5	IA1	0.703	0.703
32	Physical	Physical Function with Nursing Rehab / ADL 4-5	PA2	0.637	0.637
33	Behavioral Problems	Behavior Problem / ADL 4-5	BA1	0.612	0.612
34	Physical	Reduced Physical Function / ADL 4-5	PA1	0.575	0.575

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Exhibit D-2
Detailed Description of Data Presented in Case Mix Index Reports

Selection criteria for quarterly "Listing of Residents" reports – Residents are determined by identifying individuals for whom an MDS assessment has been received and for whom no subsequent discharge tracking document has been received. It is assumed that residents for whom a periodic assessment is more than 3 months past due have been discharged, and these individuals are not included in this report. The following data elements are selected from the most recent assessment data for patients residing in the nursing home on the last day of a calendar quarter:

AA8a, b – Reasons for assessment as reported in section AA8 of the MDS

Section a, primary reason for assessment
1 = admission assessment
2 = annual assessment
3 = significant change in status assessment
4 = significant correction of prior full assessment
5 = quarterly review assessment
6 = discharged – return not anticipated
7 = discharged – return anticipated
8 = discharged prior to completing initial assessment
9 = reentry
10 = significant correction of prior quarterly assessment
0 = none of the above

Section b, codes for assessments required for Medicare PPS or the State
1 = Medicare 5 day assessment
2 = Medicare 30 day assessment
3 = Medicare 60 day assessment
4 = Medicare 90 day assessment
5 = Medicare readmission/return assessment
6 = other state required assessment
7 = Medicare 14 day assessment
8 = other Medicare required assessment

Resident Name – Self explanatory

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SSN- Resident's social security number

Effective Date (R2b) – For assessments, this is the date completed as reported in section R2b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.

Classification Code – RUG classification code (see "Case Mix Index for All Patients" in Exhibit D-1) from application of 34 grouper with index maximizing

Classification Category – Description of RUG classification (see Exhibit D-1)

Resident ID – Identification number assigned to resident by MDS reporting system

CPS Score – 5 MDS measures (related to coma, decision-making, impairment count, severe impairment count and total dependent eating) are used to classify a resident's condition into one of the following Cognitive Performance Scale categories: intact, borderline impairment, mild impairment, moderate impairment, moderately severe impairment, severe impairment or very severe impairment.

Payment Source – Primary source of payment for services to resident based on information included in MDS assessment data. If the MDS data includes a Medicaid identification number or Medicaid pending designation, Medicaid is assumed to be the resident's payment source. If a Medicaid identification number is not present and a Medicare identification number is present, Medicare is assumed to be the payment source. If neither a Medicaid nor Medicare identification number is present, the payment source is identified as "other." A facility may submit a correction entry to the Division to note any changes to a patient's payment source that may not be reflected in MDS data. Such correction entries for payment status will be assumed to be permanent unless a subsequent correction entry is submitted for a resident.

Number of Residents, Overall CMI Averages and Medicaid CMI Average – The number of residents and average case mix index score, based on relative weights for "Case Mix Index for All Patients" in Exhibit D-1, are listed for 3 categories of residents by payment source – Medicaid, Medicare and Other. For Medicaid patients, an average case mix index score, based on relative weights for "Case Mix Index for Medicaid Patients," is also listed.

Number and % of Residents Included in CPS Add-On – The number and percentage of Medicaid residents with CPS classifications of moderately severe impairment, severe impairment or very severe impairment

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